Section 4 – FORMS

This section provides the links and some examples of the various forms used by the California Departments of Health Services and Social Services by the PHNs for the care of foster children. Please note that some form examples may be outdated and the website should be checked for the most current form.

Health and Education Passport (HEP)

http://www.hwcws.cahwnet.gov/training/nu_curr.asp

JV 220 – Application and Order for Authorization to Administer Psychotropic Medication – Juvenile

(nurses should access these forms via the child's CWS/CMS case)

http://www.courtinfo.ca.gov/forms/fillable/jv220.pdf

JV 220A – Opposition to Application for Order for Authorization to Administer Psychotropic Medication – Juvenile

(nurses should access these forms via the child's CWS/CMS case)

http://www.courtinfo.ca.gov/forms/fillable/jv220a.pdf

JV225 – Health and Education Questionnaire

(nurses should access these forms via the child's CWS/CMS case)

http://www.courtinfo.ca.gov/forms/fillable/jv225.pdf

DHS 4484 – Access ID Problem Form

http://www.dhs.ca.gov/publications/forms/pdf/dhs4484.doc

Data Form - Examples of Children Helped Through CMS (Section 4 of PFG)

A form used by CMS county programs to evaluate program needs, performance, and trends. The form is submitted with the county's annual budget plan.

http://www.dhs.ca.gov/pcfh/cms/pfg.htm

Reporting Form for Performance Measure 5 (Section 3 of PFG)

A form used by the CMS county programs to provide effective care coordinationt of their children. The form is submitted as part of the county's annual budget plan.

http://www.dhs.ca.gov/pcfh/cms/pfg.htm

CHDP Referral (PM 357)

State of California—Health and Human Services Agency — Department of Health Services

CHDP REFERRAL

All Medi-Cal eligible persons under 21 years of age can receive a health and dental check-up.
Client: Fill in unshaded areas only.

PART A: Completed by county Department of Social Services (DSS)/welfare staff for all cases requesting services or additional information

1. Case name (last)	(first)	(middle)	2. County code	3. Aid code	4. Case number

5. ☐ Requested additional information, but no services.

Requested Medical Services (Health Assessment)			Requested Dental Services		
6. Services ☐ Yes ☐ No	7. Transportation ☐ Yes ☐ No	8. Scheduling ☐ Yes ☐ No	9. Services ☐ Yes ☐ No	10. Transportation ☐ Yes ☐ No	11. Scheduling ☐ Yes ☐ No

12. ☐ New application 13. ☐ Redetermination 14. ☐ Self-referral 15. ☐ CALWORKs

16. ☐ Foster care 17. ☐ Medi-Cal only 18. ☐ Share-of-cost

19. Primary language, if other than English _____ 20. Other circumstances _____

	Person Number	Client(s) Name (Last, First, Middle)	Birth Date Month	Day	Year	Age	If health care plan member, give plan name
21.		Parent or caretaker name					
22.		Other parent in home					
23.		Child's name					
24.		Child's name					
25.		Child's name					
26.		Child's name					
27.		Child's name					
28.		Other person in home					

29. Residence address (number, street)	City	State	ZIP code	32. Home phone
		CA		( )
31. Mailing address (if different) (number, street, P.O. Box)	City	State	ZIP code	32. Message phone
				( )

33. Family or child's doctor (optional)	34. Family or child's dentist (optional)

This information is requested to meet federal requirements (Federal Register CFR 42, Part 441) and to inform you of services available. The county is required by law to keep this information confidential except as provided in state or federal law or regulation. Further information is available at your local welfare or CHDP offices.

Comments:

35. DSS worker signature	36. DSS worker number	37. DSS worker telephone	38. Date eligibility determined

Copy 1—County CHDP Copy 2—County CHDP Copy 3—Client Case Report (Welfare Department)
CHDP Referral and Case Management Form

12-1204.34

PM 357 (6/99) Required Form

PART B: Completed by EPSDT staff to document assistance with requested health assessment and/or dental services.

Case name (last) (first) (middle)

Contact attempt with responsible person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted	FINAL RESULT:
☐ Face-to-face							☐ Contact made
☐ Telephone							☐ No contact made
☐ Mail							

Comments:

Client Name		Type T	Type S	Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept Yes	Appt. Kept No	Further Dx/ Rx Needed Yes	Further Dx/ Rx Needed No	Source of Info.	Date PM 160 Received
	M												
	D												
	M												
	D												
	M												
	D												
	M												
	D												

(If more space is needed, attach additional sheets.)

Comments:

EPSDT worker signature Date

Part C: Completed by CHDP program staff to document follow-up to diagnosis and treatment.

Contact attempt with responsible person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted	FINAL RESULT:
☐ Face-to-face							☐ Contact made
☐ Telephone							☐ No contact made
☐ Mail							

Comments:

Client Name	Type of Condition	Response to Offer Trans.	Response to Offer Sched.	Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept Yes	Appt. Kept No	Source of Info.

Comments:

CHDP Health Professional Signature Date

PM 357 (6/99) Required Form

INSTRUCTIONS FOR COMPLETING PART A

ITEM

1–4 Self-explanatory.

5 Check the box if no services are requested but the client wants additional information about the program.

6 Check yes or no as appropriate.

7–8 If item 6 is checked no, skip these items. If item 6 is checked yes, check the boxes in both items 7 and 8 indicating the response to the offer of transportation and scheduling assistance.

9 Check yes or no as appropriate.

10–11 If item 9 is checked no, skip these items. If item 9 is checked yes, check the boxes in both items 10 and 11 indicating the response to the offer of transportation and scheduling assistance.

12–13 When the referral is being made by a CalWORKS, Medi–Cal, or placement worker, check item 12 if the request for services is from a new application or restoration or item 13 if the request is made at the annual redetermination.

14 When services have been requested directly from the local EPSDT Unit or CHDP Program, check item 14.

15–17 Check the one applicable box.

18 Check the box when a Medi–Cal only beneficiary has to pay a share of the costs.

19–20 Complete if applicable. Indicate special communications needs such as deaf, blind, or illiterate—for other circumstances, item 20.

21–28 Fill in the state person number (Example: 01-father, 02-mother, 11-child, etc.), and the name of the health care plan, if applicable. A person number need not be entered on self-referrals. The unshaded portion must be completed in full by the county welfare department, local EPSDT Unit, or CHDP Program staff for self-referrals, or may be completed by the client.

29–32 Record the caretaker's address and telephone number.

33–34 Optional—not required. Enter the name of the doctor or dentist who currently provides care the eligible children.

Comments: Use this section to record any comments which will help recipients receive requested services, such as the best time for them to be contacted.

35–37 Self-explanatory.

38 "Date eligibility determined"—Enter the date the application is determined eligible, not the date the application was made. For redetermination, the date eligibility determined is the date that the county verifies and certifies that eligibility continues. For "self-referrals" the date of request for services should be entered.

12.1204.35.a

PM 357 (6/99) Required Form

CHDP Referral for SAWS Automated Template

SOME COUNTY
DEPARTMENT OF SOCIAL SERVICES
760 Madison Avenue
P.O. Box 4650
Anywhere, CA 95973

SAWS CHDP REFERRAL

Date:

CASE INFORMATION

CASE LAST NAME FIRST M APP CO AID CODE CASE NUMBER

29 84

RESIDENCE ADDRESS HOME TELEPHONE:
MESSAGE PHONE:

MAILING ADDRESS:

CASE STATUS PRIMARY LANGUAGE

DATE ELIGIBILITY DETERMINED:

☐ NEW APPLICATION ☐ REDETERMINATION ☐ SELF-REFERRAL
☐ CALWORKS ☐ FOSTER CARE ☐ MEDI-CAL ONLY ☐ SHARE OF COST

OTHER CIRCUMSTANCES: _____

PARENT/CARETAKER

PERS LAST NAME FIRST M BIRTH AGE IF HEALTH PLAN MEMBER, GIVE PLAN NAME

PERS CHILD'S LAST NAME FIRST M BIRTH AGE IF HEALTH PLAN MEMBER, GIVE PLAN NAME

OTHER PERSON IN HOME:

REQUESTED MEDICAL SERVICES: SERVICES? Y/N TRANSPORTATION? Y/N SCHEDULING? Y/N

REQUESTED DENTAL SERVICES: SERVICES? Y/N TRANSPORTATION? Y/N SCHEDULING? Y/N

REQUESTED ADDITIONAL INFORMATION BUT NO SERVICES? Y/N

FAMILY DOCTOR:

FAMILY DENTIST:

FORM PM 357 Revision Date: March, 1999

CHDP Referral for Welfare Case Data System Counties

PM 357
DEL 4/87

BD50120--5Z

COUNTY OF ALAMEDA
WELFARE CASE DATA SYSTEM
CHDP REFERRAL FORM

CDS286

CODE 4 SW EW WH6H

CASE NAME LAST FIRST AID-T MS-X CASE NUMBER ELIG. DET. DATE 4-14-00

PAYEE -

PHONE NUMBER-

LANGUAGE-

OAKLAND CA 94603-1602

CASE REFERRED FOR- MEDICAL AND DENTAL WITH SCHEDULING/TRANSPORTATION

ELIGIBLE PERSONS IN CASE REFERRED

PERS NBR	FIRST	LAST	SEX	BIRTHDATE	HC
11	YAS		F	8-13-92	N
12	AD		M	9-28-97	N
13	UNBORN			9-25-00	N

PART B: FOLLOW-UP TO HEALTH ASSESSMENT AND/OR DENTAL SERVICES
CONTACT ATTEMPT WITH RESPONSIBLE PERSON:

TYPE OF CONTACT	DATE	RESULT	WHO CONTACTED	DATE	RESULT	WHO CONTACTED
☐ FACE - TO - FACE						
☐ TELEPHONE						
☐ MAIL						

COMMENTS:

FINAL RESULT:
☐ CONTACT MADE
☐ NO CONTACT MADE

PART B CONTINUED ON REVERSE SIDE

PM 160 – Confidential Screening/Billing Report

State of California—Health and Human Services Agency

Department of Health Services

[redacted]

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

7

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NUMBER | L.A. CODE

BIRTH DATE Month Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Month Day Year

Ethnic Code: 1—American Indian, 2—Asian, 3—Black, 4—Filipino, 5—Mexican American Hispanic, 6—White, 7—Other, 8—Pacific Islander

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE NUMBER) (CITY) (ZIP CODE)

S

CHDP ASSESSMENT

Indicate outcome for each Screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow-up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY AND PHYSICAL EXAM	A				01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT			M		08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

DATE OF SERVICE Month Day Year

FOLLOW-UP CODES

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED.
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED.

REFERRED TO | TELEPHONE NUMBER

REFERRED TO | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA.

CODE	OTHER TESTS—PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS

P

HEIGHT IN INCHES: 0 4 | WEIGHT Pounds Ounces | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT .0% | BIRTH WEIGHT Pounds Ounces

ROUTINE REFERRAL(S) (✓): ☐ BLOOD LEAD ☐ DENTAL | PATIENT IS A FOSTER CHILD (✓) ☐

ICD 9 CODES 1 2 3

I

THE QUESTIONS BELOW MUST BE ANSWERED.

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

	Yes	No
1. Is patient exposed to passive (second-hand) tobacco smoke?	☐	☐
2. Is tobacco used by patient?	☐	☐
3. Is patient counseled about/referred for tobacco use prevention/cessation?	☐	☐

E

PATIENT VISIT (✓): 1 ☐ New Patient or Extended Visit 2 ☐ Routine Visit

TYPE OF SCREEN (✓): 1 ☐ Initial 2 ☐ Periodic

TOTAL FEES

PROVIDER OF SERVICE: Name, address, telephone number (please include area code)

PROVIDER NUMBER

1 ☐ Enrolled in WIC 2 ☐ Referred to WIC

NOTE: WIC requires Ht., Wt., and Hemoglobin/Hematocrit

1 ☐ PARTIAL SCREEN 2 ☐ SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

1 ☐ If covered by Medi-Cal or preenrolled in CHDP Gateway, enter BIC number above.

2 ☐ Patient eligible for CHDP benefits only.

SITE OF SERVICE IF OTHER THAN ABOVE:

This is to certify that the screening information is true and complete, and the results explained to the child or his/her parent or guardian. I understand that payment and satisfaction of this claim may be from federal or state funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable federal or state law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA—CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

COPY 1—MAIL TO MEDI-CAL CHDP

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (7/03)

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320

(916) 327-1400

PM 160 (7/03)

PM 161 – Confidential Referral/Follow Up Report

Online Version: http://www.dhs.ca.gov/publications/forms/pdf/pm161.pdf

State of California—Health and Human Services Agency

Department of Health Services
Child Health and Disability Prevention Program

CHDP CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT

CHDP Health Assessment Provider:

- Retain original form in patient's medical record.
- Send photocopy to diagnosis/treatment provider.

Diagnosis/Treatment Provider:

- Complete and sign form. Retain the signed form in patient's medical record.
- If patient consent is given, send photocopy of completed and signed form to the CHDP Health Assessment Provider.
- If patient consent is given, send photocopy of completed and signed form to the local CHDP program. To find the mailing address for the local CHDP Program, go to www.dhs.ca.gov/chdp.

CHDP HEALTH ASSESSMENT PROVIDER COMPLETES THIS SECTION:

Patient name (Last) (First) (Initial) | BIC number

Date of birth Month Day Year | Sex ☐ Female ☐ Male | Patient's county of residence | Code | Telephone number

Responsible person (Name) (Street) (City) (ZIP code)

Dear _____:
(Diagnosis/Treatment Provider)

The above named patient received a CHDP health assessment on _____. The following suspected condition(s) was identified as needing further evaluation:
(Date)

1. _____

2. _____

3. _____

After you have seen and examined the patient, please note your findings below. If appropriate consent has been obtained below, please send a photocopy to me and/or the local CHDP program. Thank you,

Printed name of CHDP Health Assessment Provider | Signature | Date

Mailing Address (street, number) | City | ZIP code | ( ) Telephone number

PARENT COMPLETES THIS SECTION:

CONSENT: I have read the release of information disclosure on page 2 and I hereby authorize release of information to:

☐ Local CHDP Program ☐ CHDP Health Assessment Provider

Signature of Responsible Person | Date

DIAGNOSIS/TREATMENT PROVIDER COMPLETES THIS SECTION:

A. What was your diagnosis (ICD terminology) of **suspected condition 1**?	What was your diagnosis (ICD terminology) of **suspected condition 2**?	What was your diagnosis (ICD terminology) of **suspected condition 3**?
ICD Code *(optional)*	ICD Code *(optional)*	ICD Code *(optional)*
B. Result of diagnosis: *(Check appropriate line.)*	**Result of diagnosis:** *(Check appropriate line.)*	**Result of diagnosis:** *(Check appropriate line.)*
☐ Abnormality not confirmed	☐ Abnormality not confirmed	☐ Abnormality not confirmed
☐ Abnormality confirmed:	☐ Abnormality confirmed:	☐ Abnormality confirmed:
☐ No treatment indicated	☐ No treatment indicated	☐ No treatment indicated
☐ Treatment indicated—given	☐ Treatment indicated—given	☐ Treatment indicated—given
☐ Treatment indicated—referred	☐ Treatment indicated—referred	☐ Treatment indicated—referred
☐ Treatment indicated—not given nor referred	☐ Treatment indicated—not given nor referred	☐ Treatment indicated—not given nor referred
Reason:	**Reason:**	**Reason:**

Diagnosis/Treatment Provider signature ➤ | Date examined Month Day Year | Diagnosis/Treatment Provider's telephone number ( )

PM 161 (4/03) Page 1 of 2

RELEASE OF INFORMATION DISCLOSURE

To the responsible person:

When your child or you are referred for diagnosis and/or treatment as a result of a CHDP health assessment, this form will be used to assist in the referral. Certain information regarding the reason for referral will be written on this form.

The original will be kept in your child's or your confidential patient file by the CHDP health assessment provider, and a copy will be sent to the health care provider or agency providing diagnostic and/or treatment services.

The results of the diagnostic and/or treatment services will be recorded on the copy. It will be kept by the diagnostic and/or treatment provider in your child's or your confidential patient file. With your permission, copies will be distributed as follows:

- A copy will be sent to your local CHDP program to let them know that your child or you received the recommended services. The director or the deputy director of the local CHDP program at your local health department has the responsibility to maintain this copy as a confidential record.

- A copy will be sent to the CHDP health assessment provider to let this provider know that your child or you received the recommended services. This copy will be kept by the health assessment provider in your child's or your confidential patient file.

PM 160 Sample Forms and Instructions

For PM 160 sample forms and instructions, see also the CHDP Provider Manual at the link below.

http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/CHDP_search.asp

Click on CHPD Provider Manual > scroll down to Confidential Screening Billing Report (PM160) > click on appropriate link

CHDP Forms and Publications

The following link provides a list of the brochures, flyers/forms/manuals and reports available.

http://www.dhs.ca.gov/pcfh/cms/chdp/publications.htm#forms